ONCE-DAILY
INGREZZA® (valbenazine) capsules

TREATMENT FORM

INBRACE® SUPPORT PROGRAM

For additional assistance, call 84-INGREZZA (844-647-3992), 8 AM–8 PM ET, M–F.

INSTRUCTIONS: Please complete and fax this page to 844-394-7155.

1 PATIENT INFORMATION

First Name:	Last Name:	Last 4 digits of the SSN:	DOB: / /
Address:	City:	State:	ZIP:
Preferred Phone:	Mobile Phone? ☐ Yes ☐ No	Gender: ☐ Male ☐ Female	
Alternate Phone:	Email:		
Alternate Contact/Care Partner:	Alternate Contact/Care Partner Phone:		

(Optional) I consent to have my prescription shipped to: ☐ Care Partner ☐ HCP office

Patient Signature: Date:

By signing here, I authorize the use and disclosure of my PHI as set forth in the HIPAA Authorization on page 3.

2 PATIENT INSURANCE INFORMATION–Please attach a copy of the patient's insurance card. (Check below if no insurance)

☐ Patient does not have insurance.	**Medical Insurance Name:**	**Prescription Insurance Name:**	
Phone:	Cardholder ID #:	Phone:	Cardholder ID #:
Policyholder Name & DOB: / /		BIN:	PCN:

3 CLINICAL INFORMATION

Primary Diagnosis Code Category: ☐ **Tardive Dyskinesia (G24.01)**	☐ Other diagnosis:	Allergies:

4 PRESCRIPTION FOR INGREZZA (valbenazine) CAPSULES

PRESCRIPTION INSTRUCTIONS: Check one Rx box below.

☐ **Initial Rx with 80 mg Maintenance Rx**
40 mg once daily x 7 then
80 mg once daily x 23.
No refills.
80 mg once daily.
1-month supply. **Refills #____**

OR

☐ **Initial Rx with 40 mg Maintenance Rx**
40 mg once daily
1-month supply. **Refills #____**

OR

☐ **60 mg Maintenance Rx Only***
60 mg once daily
1-month supply. **Refills #____**

OR

☐ **80 mg Maintenance Rx Only***
80 mg once daily
1-month supply. **Refills #____**

☐ **Other Rx** Sig: _____ Quantity: _____ Other Rx Refills:____

Preferred Pharmacy if applicable: ☐ Amber Pharmacy ☐ Orsini Healthcare ☐ PANTHERx® Specialty Pharmacy ☐ No Preference

*If 40 mg in-office samples were used, you may choose to select 60 mg or 80 mg Maintenance Rx Only.

5 PRESCRIBER INFORMATION

Prescriber Name:			Prescriber NPI #:
Facility Name:			Provider Phone:
Address:	City:	State:	ZIP:
Office Contact Name:	Phone:	Fax:	Email:

6 PRESCRIBER CERTIFICATION

I certify that the information provided in this INGREZZA® (valbenazine) capsules Treatment Form is complete and accurate to the best of my knowledge, I have prescribed INGREZZA based on my judgment of medical necessity, and I will supervise the patient's medical treatment. I certify that, where required by federal and/or state law, I have obtained my patient's written legal permission to share identifiable information with Neurocrine Biosciences, Inc., its agents and pharmacies, including but not limited to the INBRACE Support Program Pharmacy and the pharmacies listed in Section 4 above. I authorize the forwarding of this prescription and information to a dispensing specialty pharmacy. If the patient has requested shipment to my office, I agree not to receive any compensation for dispensing the product and I will clearly label and dispense only for use by the patient.

Prescriber Signature: Date:

*(Original signature required - *If required by applicable law, please attach copies of all prescriptions on official state prescription forms)*

Please see Indication and Important Safety Information on page 2.

Neurocrine BIOSCIENCES

 CP-VBZ-US-0252v7 06/2021

Important Information

INDICATION & USAGE

INGREZZA® (valbenazine) capsules is indicated for the treatment of adults with tardive dyskinesia.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

INGREZZA is contraindicated in patients with a history of hypersensitivity to valbenazine or any components of INGREZZA. Rash, urticaria, and reactions consistent with angioedema (e.g., swelling of the face, lips, and mouth) have been reported.

WARNINGS & PRECAUTIONS

Somnolence

INGREZZA can cause somnolence. Patients should not perform activities requiring mental alertness such as operating a motor vehicle or operating hazardous machinery until they know how they will be affected by INGREZZA.

QT Prolongation

INGREZZA may prolong the QT interval, although the degree of QT prolongation is not clinically significant at concentrations expected with recommended dosing. INGREZZA should be avoided in patients with congenital long QT syndrome or with arrhythmias associated with a prolonged QT interval. For patients at increased risk of a prolonged QT interval, assess the QT interval before increasing the dosage.

Parkinsonism

INGREZZA may cause parkinsonism in patients with tardive dyskinesia. Parkinsonism has also been observed with other VMAT2 inhibitors. Reduce the dose or discontinue INGREZZA treatment in patients who develop clinically significant parkinson-like signs or symptoms.

ADVERSE REACTIONS

The most common adverse reaction (≥5% and twice the rate of placebo) is somnolence. Other adverse reactions (≥2% and >placebo) include: anticholinergic effects, balance disorders/falls, headache, akathisia, vomiting, nausea, and arthralgia.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit MedWatch at www.fda.gov/medwatch or call 1-800-FDA-1088.

Please see accompanying INGREZZA full Prescribing Information

Patient HIPAA Authorization for Use and Disclosure of Protected Health Information

I authorize Neurocrine, companies working with Neurocrine, my healthcare provider and pharmacy to use and disclose to Neurocrine, and companies working with Neurocrine, my Protected Health Information ("PHI"), such as information provided on the INGREZZA Treatment Form, my prescription, insurance, medical therapy information and other PHI for the following purposes: (1) providing financial assistance options, (2) reimbursement support, (3) medication compliance and persistence, (4) information about Neurocrine products and programs, which may from time to time include requests to participate in market research or other initiatives related to my experiences with Tardive Dyskinesia and/or INGREZZA, and (5) other treatment-related services, including providing information and materials related to the INBRACE Support Program (collectively called "Support Services"). I authorize the disclosure of my PHI to communicate with the Alternate Contact/Care Partner listed in Section 1 of the Treatment Form. I understand that the companies working with Neurocrine, including my pharmacy, may receive payment for the use and disclosure of my PHI. I understand that once it is disclosed, it may be re-disclosed by the recipient(s). After such a disclosure, the information may no longer be protected by HIPAA or the terms of this authorization against further re-disclosure. I understand that this authorization shall continue in effect for a period of ten years unless a shorter period is required by law. I understand that I may revoke this authorization to use or disclose my PHI by contacting an INBRACE Support Program representative by telephone (844-647-3992) or by mailing a letter to Neurocrine, Attn: INBRACE Support Program, 12780 El Camino Real, San Diego, CA 92130. I understand that my healthcare provider, pharmacy, and/or Neurocrine will not condition my treatment on signing this Authorization. I can choose not to sign this Authorization. However, if I choose not to sign, Neurocrine will not be able to help me with Support Services as described above. I may obtain a copy of this Authorization upon request.

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